

Performance Improvement, Healthy People & The Community Guide

CDC Performance Improvement Managers Network Call

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Sarah (Operator): Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After today's presentation we will conduct a question and answer session. To ask a question at that time, please press star-1. Today's conference is being recorded. If you have any objections please disconnect at this time. I would now like to turn the call over to Ms. Liza Corso. Ma'am you may begin.

Liza Corso: Thank you very much. Welcome to the March Perform-the April Performance Improvement Managers Network call. I'm Liza Corso, the PIM Network Coordinator with the Office for State, Tribal, Local, and Territorial Support and I'm joined here today by colleagues from OSTLTS. And Teresa Daub is in the room with me and she and I will be co-moderating this call. We're delighted that you could join us for today's call. This is our third call in the monthly call series for performance improvement managers throughout the country.

It may be the first call for some of you who are new to your positions so I want to mention first that the Performance Improvement Managers Network or the PIM Network as we like to call it, is an activity of the National Public Health Improvement Initiative and it's intended to be a forum to support the performance improvement managers in learning from each other as well as from experts in the field. These calls are a way for members of the network to get to know each other better, learn about best practices and quality improvement, performance management and share information about resources and training opportunities.

Many of you are working now to establish a performance management system which are performance improvement offices. So on today's call we're going to hear from Dr. Jonathan Fielding who's going to be discussing Healthy People and the Guide to Community Preventive Services often referred to as The Community Guide. And he'll also be sharing his local health departments' experiences in linking their



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performance improvement efforts with these two national resources. But before I introduce him further, Teresa's going to review first some of the technological features of today's call.

Teresa Daub: Thank you Liza. And welcome everyone to the PIM Network call today. There are slides for those of you who are able to join the net conference link you can see as we go through the link or through the presentation. For those of you who aren't able to join the net conference site, you can follow along via the slides that you were emailed earlier today in PDF format and our speaker will very generously indicate 'next slide,' so that you all will know how to move through the presentation. Also if you're on the website today and you're curious to know who else is participating, if you go to the top of your menu bar you'll see a tab, the second from the left, with 'Attendees.' You click on that and view the attendees.

We are going to take questions on today's call as you heard from our operator. One way that will occur is at the end of the call, but if you have questions throughout the call, you may use the Q&A box that's on the net conference site. It's at the bottom right of your screen. You may type your question into that box at any time and we'll also take the live questions at the end. But if you're interested in remaining anonymous and framing your question via the Q&A feature, please use 'anon' either before or after your question so we can honor that request appropriately.

Today's call will last approximately an hour and it is being recorded. The great thing that we can do with the recording is post it on the PIM Network webpage at CDC and also on the PIM Network virtual gathering space which is on the phConnect site. Hopefully you all have received instructions via email about how to connect with the phConnect site and join that community. It's intended to be a virtual community where performance improvement managers, CDC staff, national partners and others can interact, exchange information, post resources, seek help from each other. So please follow up on that if you haven't already. If you need additional information from us, your CDC staff, please contact us at pimnetwork@cdc.gov and we'll be glad to assist you with connecting to the phConnect Community.

There will be a few polls on today's call. We're going to start the first one right now. I'll introduce each poll and announce when it's open and you may cast your vote by selecting your response with a mouse click. So the first poll question is to give us some idea of who's participating on the call today. And the polls are now open so we're curious to know if you're representing a state health department, a tribal health department, a local health department, territorial health department, national public health organization, or other...and if you're other, we are curious to know how you got here. (*Laughter*). Please continue casting your votes...and you should also be able to see those on the screen. So you can see that we have a pretty good representation from a variety of health departments. A majority being no surprise because of where PIMs are located in states, with the state health department.

We'll go on to our second poll, which is going to give us an idea of how many people are on the line today since many people have joined together to participate in the call. We're interested to know how many people are in the room where you are. So please respond to the poll. Okay, it looks like we have



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some folks who have joined with friends and colleagues to participate, but many people participating alone. Again, thank you for participating in that poll. We will have a final poll at the end of the call just to ask you your thoughts about today's call. We really appreciate and look forward to your feedback so we would like for you to participate then. But for now I'm going to turn back to Liza to introduce today's speaker.

LC: Thank you so much, Teresa. I am so pleased to introduce today someone who has been a national leader as well as a leader for a health department who has done significant work in performance improvement. We'll hear from our speaker today before we take questions but as a reminder you may type in questions any time during the presentation. We'll also take audio questions after the presentation which you'll be able to submit by pressing star 1 on your telephone. Today's presentation will include a concise overview of Healthy People and the Community Guide. I want to first say we understand there are different levels of familiarity among the PIM Network with these resources and we're only able to go so deep on a conference call. So please know that there are resources listed at the end the presentation and we'll also share these and others for further in depth study via the PIM Network communication channel.

We're excited to have Dr. Jonathan Fielding speaking with us today. Dr. Fielding is the director of the Los Angeles County Department of Public Health and the County Health Officer responsible for all the Public Health functions for the county's ten-plus million residents. He directs the staff of about four thousand with an annual budget exceeding eight hundred million. Dr. Fielding also chairs the U.S. Community Preventive Services Task Force which oversees the work of the Community Guide that you'll be hearing about. And he also chairs the HHS Secretary's Advisory Committee on the 2020 health objectives for the nation which has been responsible for the Healthy People 2020 work which you will also be hearing about. He also has been a founding member of the U.S. Clinical Preventive Services Task Force which developed the Companion Guide to the Community guide which is called the Guide to Clinical Preventive Services. For the sake of time, I'm not going to list the many other appointments you hold or have held or the many prestigious awards he has received. Just now he is a national public health leader in these areas and we are just so very honored to have him with us today. Dr. Fielding, the floor is yours.

Dr. Jonathan Fielding: Well thank you so much. I'm so glad to be with you and one perspective I would add about my background is I was a state Health Officer so I understand the perspective of both states, local and of course federal where I've also worked. But what I really want to do today is talk about evidence, talk about how we use it to in fact make programmatic decisions and then how we try to figure it on the issues of quality, how that in fact, how those all come together. And we all know that these have-evidence is really the cornerstone of our practice and, and really the, the basis of our credibility. I think that the book *The Community Guide* and *Healthy People 2020* are critical guides in both identifying and applying evidence. And I think we have to integrate these approaches into our performance improvement strategies and activities. A broad focus that brings us all the essential services in is to link performance with our population outcomes and one of the most important things is



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using tools to prioritize our work efforts to focus on those that are most likely to succeed and to have the greatest impact.

It may be axiomatic on the next slide but why is evidence essential to public health practice? Well it provides access to more and higher-quality information on what works. Now everything is evidence including everybody's opinion, but the quality of evidence I'm talking about particularly is that derives from careful systematic reviews of all of the peer-reviewed literature. This provides a higher likelihood of program success and a higher likelihood of a policy being implemented because it's a very time-consuming even if it doesn't consume a lot of dollar costs in trying to put in place policies that in fact have not been shown to be effective if we have one that has. We also get therefore greater workforce productivity and we're able to increase accountability by supporting more and better use of public and private resources. And there's no time like today in terms of the fiscal climate where efficiency and effectiveness are really important hallmarks of everything we do.

Next slide please. So what are the hallmarks of evidence-based public health? Well making decisions based on the best available peer-reviewed evidence and sometimes that'll be qualitative research other times it will be quantitative and sometimes mixed. Using the data and the information systems systematically having a reproducible way to look at data, that means applying program planning frameworks, oftentimes these have their foundation in behavioral science theory which I'm sure many of you are familiar with. Engaging the community in assessment and decision-making. The community can be a small neighborhood. It can be a federal government, it can be a state, it can be a city, it can be a county. Conducting sound evaluation. We really want to know how we're doing not just assuming what we've done is effective. And then this is part of the effort of this webinar to in fact disseminating what we've learned to key stakeholders and decision makers which is something I would say all of you should say yes to.

The next slide please. So let me just go briefly over the Guide to Community Preventive Services. It's a resource which continues to expand. It is, this is the printed version you see, but its, its most important to go online because that's the most updated version. It is directed by the Task Force on Community Preventive Services with great scientific support from the CDC and excellent liaisons to many of the key organizations to ASTHO, to NACCHO, to NALBOH, to the AMA, to other federal agencies. So it's really critical to have everybody in the tent. The task force itself is an independent, non-federal, volunteer body of experts in public health and prevention research. Some of whom are in practice, some in policy, some in both, appointed by the director of CDC to both prioritize the topics and then oversee the reviews which includes developing recommendations based on the results of these reviews as well as being a critical input into what are the opportunities for further research. What's kind of the low-hanging fruit if you will for research? What are the questions we thought we could answer from the literature that in fact the research did not answer for us.

Next slide please. So how does The Guide identify these evidence-based interventions? Well they do it by systematic reviews to understand what interventions have worked and what settings and populations



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has it worked in and does it have associated other benefits or harms or both with the intervention in addition to the primary impact we're trying to have.

Next please. We convene—Next slide please. I'm sorry; we're going to need to go back. I'm afraid we, there we go, we convene review teams on topics that have been prioritized, we develop a conceptual framework, a "logic model"—I can't stress this too much. You need to have a clear logic model of what affects what so that you know where interventions fit. We develop a prioritized list of interventions to evaluate based on a set of clearly identified criteria, a certainly preventable burden is one interest, extent of use are others and then we develop and refine the conceptual approach which is a then, an analytic framework which again is a piece of the logic framework that focuses on the specific opportunity to make a difference with that intervention. We establish criteria for inclusion and exclusion of studies because when you start looking you find, oftentimes thousands of studies that have the search word, but then don't winnow them down very quickly. We search for evidence that way, critical evaluate and summarize the evidence. We code all the study data. We assess—we look at two things: we assess the study quality and both the design and the conduct of the research and we create in essence a body of evidence. And then we look at the applicability and implementation barriers of those.

So next slide please. Then we summarize the information on other benefits and harms and we identify research gaps and develop the recommendations. Now very important and underutilized because the literature is really not there in many cases, is an economic evaluation of the interventions that have already been found effective. You know, if you look at cost utility, cost benefit and cost effectiveness analysis, oftentimes there isn't the data to do that. Probably the most important URL I can give you is thecommunityguide.org, which is shown on that slide. And I'd give you a sense of the topics on the next slide, which you can see are relatively broad and in some cases crosscutting. It's always a question whether to look at risk factors if you will or to look at the impact and what you see here is a mix of a both.

Next slide please. But what we, here are the key questions we ask about each intervention. Does it work? Does it work for different populations? And then under what circumstances are these interventions appropriate? Because they may not be appropriate under all circumstances and what do they cost? And oftentimes, in fact it's rare that we find interventions where we know the cost even if their programmatic often time cost isn't available. And do they provide value? Which is another way of saying, you know, is the cost worth the help benefit? We'll put cost on one side and help benefit on the other side of the equation. And then what are the barriers to their use? We know from our experience and your experience that nothing is easy. And so what are the barriers? How substantial are they? Are they ones we're familiar with? Then are there any harms that we expect? And are there any unanticipated or any anticipated outcomes.

So. The findings then derive from a table of evidence and they can be in three categories. One we can recommend something based on strong or sufficient evidence if the intervention is effective. We can and occasionally do recommend against because there's strong or sufficient evidence that the



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intervention is harmful or not effective. And then often times and certainly perhaps less often than you might expect we find insufficient evidence that the studies really just don't give us enough evidence. In some cases the effect size is very, very small but well distributed. In other cases some studies are positive, some are negative, and there's not a clear pattern.

Community Guide includes intervention at the individual level. For example, mass media campaigns to reduce alcohol impaired driving and trying to get to everybody to understand the importance of that. Educational programs to increase the use of car safety seats. Counseling and skill building. An example would be school based programs to prevent violent behavior. Or incentives rewarding workers for participating in smoking programs or law enforcement sobriety checkpoints. So while it's a Community Guide there are some interventions that we want to try and reach everybody overall or everybody in a particular target population and those are at the population level even though it's a population of individuals.

We also have—Thank you. This is the right slide. We also have interventions that work at the systems level. So nothing is more important than terms and determinants of health and our built and our social environments. In the built environment we're looking at land-use policies and practices, we're looking at urban design and to the degree that those support increased physical activity as an example. Another example in the social environment that we've looked at is the effects of early child and home visitation programs, but those are outside the healthcare system. We also look at the healthcare system and within the healthcare system these are recommendations that can be looked at as complimentary to those of the US Preventive Services Task Force that makes the clinical recommendations for the one-on-one encounters between a patient and a healthcare provider. We're looking at the system impact. So, whereas here we have the example of provider reminder systems to increase the delivery of Preventive Services, so as an example, when immunization, what immunizations are recommended come from the ACIP. But how to make sure that those recommendations are then taken up and used by as many as possible to achieve the goals for an adequately immunized population, those, some of those strategies derive from healthcare system opportunities and what we do is look at those carefully and then we also look at policies, the IRAs, for example the smoking bans and restrictions.

So let me give you a more concrete example. On the left hand side you have the guide to clinical preventive service, that's the clinical guide, that's aimed at the one-on-one relationship between a physician and a patient. Take the examples of colorectal cancer screening. We recommend small media to promote cancer screening. We're not recommending whether you should or should not screen for colorectal cancer but assuming in fact that there is a good reason to screen for colorectal cancer, to screen for cervical cancer, and breast cancer. We've looked at the evidence that small media, pamphlets, brochures, and other kinds of information do help promote cancer screening. We also find that reducing out of pocket costs make in fact a big difference in terms of utilization rates. And then we talked about other barriers that can be reduced. For example, client reminders healthcare provider assessment and feedback and healthcare provider reminder and recall systems. All of these increase the



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rates of cancer screening. I will be happy to answer questions about the Community Guide in our Q and A period. Let me move on to Healthy People.

Next slide please, thank you. This was launched in 1979 with the surgeon general's report on health promotion and disease prevention. Dr. Julius Richmond at that time was the surgeon general. It's been updated every decade since and it's had more priority and more focus areas, and more health objectives, and more interest by a large number of participants in this process over time. So for 2020, there were five hundred and seventy objectives in the forty-two topic areas. At the beginning of this process, it relied primarily on expert opinion. We now have a process that both uses the best evidence but also gets a lot of stakeholder input at every stage. So here are the Healthy People 2020 goals and I would argue these are good goals for every state and local health department.

First: To attain high quality longer lives free of preventable disease, disability, injury, and premature death. So longer lives and healthier lives if you will.

Secondly: To achieve health equity, eliminating disparities, and improving the health of all groups. The social justice issues.

Create social and physical environments that promote good health for all recognizing the criticality of those health determinants.

And then promote the quality of life, healthy development and healthy behaviors across all life's stages. This recommends, this recognizes the importance of trajectory and the fact that there are critical periods where interventions can make a big difference for the rest of one's life.

Some of the strengths of Healthy People is that it does recognize the importance of social determinants. It provides evidence-based interventions to help implement and utilize the initiative: that's where we'll talk in a minute about how this kind of works with the Community Guide. It offers for the first time, a web based system that allows the users to get the information they need and it's much more flexible. Before I know those of you who have ever lifted the 2010 Healthy People know that it may be very good for a strength-building exercise, but it might be less easy to use as a reference tool. It was very, very large volumes. This also the web, allows revision updating of objectives over the course of the decade because knowledge isn't standing still; we have a lot of new knowledge. And it can revise the objectives and topic areas to better meet the needs of users.

One of the most important advances in 2020 was a number of new topics that are on this slide. I would point out several things. First of all dementia including Alzheimer's disease, hard to believe it wasn't there before but this is a growing epidemic. Early and middle childhood because we understand the importance of trajectory and the importance of early learning. Genomics, which really wasn't very much thought about in the prior periods. Global Health: very important. And all of these of course are including the gay, lesbian, sexual, and transgender health. But health related quality of life and well being, understanding that health is not our goal, health is the thing that allows us to meet other life



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goals. And then preparedness, which before 9/11 did not have the prominence that it now does. I'd also mentioned the social determinants of health, which was probably the most difficult new one to deal with because it is in fact so broad.

So let's just take one topic and look at it and this gives you how you can interface with Healthy People dot gov. And this one the topic here is maternal, infant, and child health and you can see that it gives you both objectives and interventions and resources. It starts with an overview, talks about, in fact, how important this is and then what it does is it give you some targets for the specific objective. So on the next slide, on this slide, target you see is. One of the targets is to reduce the rate of fetal and infant death. Very, very important. So you have now fetal death at twenty more weeks of gestation are the clear indicators and you can see what the target is. We want to move from the 6.2 fetal deaths at twenty or more weeks of gestation per thousand births. To we want to move toward 5.6 fetal deaths per one thousand births and live births and fetal death. So this gives you a very clear target.

On the next slide you'll see that here we have recommendations and here's the evidence-based recommendations, clinical recommendations, community recommendations, and additional consumer information. So it talks about several different types of things, but this comes from the US Preventive Services Task Force trying to prevent tobacco use and tobacco caused disease in adults and pregnant women. Counseling and interventions we know that that is recommended based on good evidence. So look there are preventions for defects as well is recommended for women that are planning or capable of pregnancy taking a daily supplement. And then primary care interventions to promote, to promote breast-feeding. Those are all the individual recommendations.

Now with community interventions are related but in fact complimentary. So here, you have increasing tobacco use cessation, one of the opportunities is increasing the unit price for tobacco products because then people smoke less. Secondly is campaigns, mass media campaigns for tobacco cessation when combined with other interventions. So arguing that mass media alone isn't sufficient, but is extremely important to be combined with others. And then multi-component interventions, that include telephone support, is another effective, recommended, population based approach as is provided reminders. So here you have then a set, if you will, a menu from which you can choose and it doesn't mean you would only want to choose one, you would want to choose several, but it gives you a sense of what we know will work because the evidence is very clear, that it's had, that its not only been effective but it's had a reasonable effect size.

Let me now move on to the cost and cost effectiveness question we really want to know what's the health return for the dollars that we're investing and there are a lot of ways to measure that. We can measure that in lives saved and years of lives saved, in cases prevented and qualities and quality adjusted life years gained and the costs again are clear, we want startup cost, we want maintenance cost, we want fixed cost, we want variable cost, but we have certain problems trying to look at cost. First of all, very few interventions in fact look at that. Secondly we have to ask the cost to whom? Is it the federal government, is it your health department, is it the general public, is it the federal treasury, is it



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to the state government? So that's important. And then another issue when you're looking at cost, are how do you deal with the issue of policy? What is the cost of a policy? You could write, there are many books that have been written on that so we do have challenges, but wherever there's information on cost and cost effectiveness I think it's very important to use. I would argue that in prioritizing what you want to focus on at the local departmental or state health department level, the two most important issues are the preventable burden and the cost effectiveness.

Now let me turn to our experience in L.A. county and just provide you with a few of the ways that we think about this. Next slide please.

This is our organizational framework for our performance improvement efforts and you can see that we have structure, process, and outcomes. And we've looked at three different levels. We have the whole county level, we have the department level, and then we have within the department the program service or planning area levels. So at the bottom in the pink we have the public health measures if you will, those then, and those have both performance measures and population indicators. We then move to the departmental level and here we have key indicators of health at our department level in terms of outcomes but we also have a public health report card that we provide every year that looks at how we're doing in all of our programs and we have roughly forty of those. And then we have the performance counts measures at the county level, how are we doing countywide. All of these are important.

So we believe then in fact, a hallmark of what we think has to be done is continuous quality improvement and we did a key, we do frequent key indicators of health reports and we base these on results from surveys that provide relatively local level data. Again, we're a county of 10 million so it wouldn't be same the same level of aggregation as a community of five thousand. But still, it is very important to try and look at the different communities. And we show the results by geographic and demographic criteria.

So if you look at the next slide you'll see that we have, this is just an example, these are from preventive services. We have women's health. You can look at an example; the percentage of all live births where the mother receives late or no prenatal care. And notice there that we have the Healthy People 2010 goal. We have national data. We have LA county overall data. And then what we have is divided up by the different areas. We have service planning areas. And the ones in black are ones that have really very poor rates compared to the mean. And the ones in white are better. So here you see very large disparities between some areas and other areas. You can see we do same thing for colorectal cancer screening and for immunizations. Again, highlighting those that are significantly above or below the levels we're trying to achieve.

Next slide please. We use public health measures to and we do this based on results accountability framework and in this we've used the consultant from time and time Mark Friedman and I think that is the book that's indicated at the bottom there is a very useful guide to this. What we do is we look at two



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kinds of performance. We look at program level performance, which is within the domain responsibilities, accountabilities of the program. And then we looked at population-based outcomes. Which are really shared; they have to be shared with other community stakeholders because there's not, we can't do everything alone but there's almost nothing we can't do with the right partners. So we integrated these with the whole bunch of different standards the NACCHO Operational Definition standards, the accreditation board standards and measures, The Community and Clinical Guide, Healthy People, and then grant metrics. And this was championed as a QI effort in 2002 when we started this. So we have forty different units. And for them we've identified as I've indicated program performance measures and population measures.

Move to the next slide. Thank you. So, if you look at the public health measures you can see that on the right in the green there are measures of program effort and output. On the left we have the again health outcomes at the population levels. I think both of these are absolutely critical. And I'll show it again on the next slide. And from the left you have the population measures and you can see that for each population's goals we have to have shared accountability. And yet, to achieve that we need to be leaders in, in fact, bringing all the stakeholders together. We need to bring effective strategies, we need to understand the role of our program; we need to understand and convince our partners and collaborate strongly with them. On the right hand side of this program, mission and vision you have the individual program performance. So you have program customers, you have the program performance goals and those are directly the responsibility of the program heads. They are the ones in fact they control. And then in both situations we have strategies to improve performance.

The next suggests our shared accountability model with the many partners. We are under the responsibility under county government with a board of supervisors that has both legislative and administrative responsibility. We have 88 cities in Los Angeles County. We have many CBOs, many faith-based organizations. We work closely with schools. We have to work closely with many healthcare organizations and professional societies. We are fortunate to have a number of very good academic institutions and then of course we work very closely with other governmental agencies at all levels.

So next slide. This one gives you a sense of how we think about it. We developed our population goals based on our strategic plan. That purple color at the bottom left. We then ask ourselves how will we know if we in fact are meeting those goals and we look at Healthy People 2010 and Healthy People 2020 to look at the indicators that we should use. And then we look at The Community Guide, The Clinical Guide, and other sources of best evidence beside what are effective strategies. And based on all that we then can define, if you will, a program performance goals in which you're consistent with NACCHO standards on one hand or federal, state, or local guidelines. So that we have measures at both levels: at the population level and also at the individual program level. To make this real let me just use the example of, of immunization. Let's really start at the bottom. This is the program performance goal. It's associated with NACCHO standard number nine. And here's the measure. We're looking at percentage of immunization program public and non-profit clinic partners routinely met the standard for



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immunization pediatric practice for provider and patient recall reminder systems. So that's something we can control. But if you look up above, what you see is there is a population goal. On our population goal is really what we all strive to do which is to reduce morbidity and infant mortality from vaccine preventable diseases by improving immunization levels. So here we've taken the metric from Healthy People 2010 percentage of children age fifteen to thirty-five months were fully immunized as recommended by the advisory committee on immunization practice. So that's the population indicator. And then I've just put a subset of, of strategies so we've tried to recommend to providers that they put in place recall reminder systems. We used multi-component interventions with providers and we also have worked to reduce out of pocket cost working with the health plans to both increase demand and access.

Now in this very short time one of the things I want to mention to you is another way to look at the core functions of public health that may be helpful for you. In this case we're talking about we have epidemiology, which is really the monitor the health, diagnose, and investigate in the assessment functions. We also have the policy development in green. That's inform, empower, educate mobilize the partnerships at the community level and develop all of these. And then we have the quality assurance, which is enforcing laws linking to and providing care, developing and applying public health science, assuring a competent work force in evaluating. So it's a nice way of thinking about how to divide up the core functions with respect to specific responsibilities.

Difficult of course, in the next slide, is how we prioritize our challenges, because in all of what you do there is really an unlimited vista of opportunities to do good work. And you all have a lot of excellent people to work with. But the trouble is that we have limited resources and we have a lot of different drivers. On one hand we have laws, we have mandates, and we have ethical considerations, we have the underpinning science. And so I suggest that these are at least the domains that we use for prioritizing the public health problems. One, we look at the magnitude of the problem quantitatively. What percentage is at risk? What's the mortality rate? What's the economic burden? We look at other factors that are more qualitative. What degree of disparity is there in different portions of populations? How much of a concern is it? Is this something where we have a legal mandate? And then we look at the effectiveness and efficiency, efficiency of cost effectiveness of the interventions. What's the level of evidence? How cost effective is it? What's the effect size? And are we in fact addressing not only the proximate causes, but the root causes. So some of these are aspects of the social and physical environment and also the feasibility. Sometimes there are things that are not culturally appropriate. And maybe the right thing to do, we may not have the resources or maybe there's stovepipe funding to work in a particular domain of a particular organ system and that's not the one that we think is the most important. There's also an issue of timeliness. But I would add to these that it's important to have a balanced portfolio where some of the things we're doing have short-term impact and others have long-term impact. So we can get the immunization rates up probably by a number of short-term strategies. We're not going to improve the physical environment or the social environment in broad ways without thinking over a longer period of time and realizing it may take a number of steps. But just because it's



longer and maybe more difficult is not a reason to not provide a lot of emphasis on the social and the physical environment. So with that I have taken my 35 minutes and look forward to your questions. Hope this is helpful. I apologize for going over so much so quickly.

LC: Thank you so much Dr. Fielding. I think that you certainly covered a lot of material and I hope folks found that useful particularly since both Healthy People and The Community Guide are resources cited in the FOA that they responded to for year one as well as of course the supplemental FOA that they are probably all looking at right now

JF: I assume that I'm speaking to a group of experts.

LC: Oh yes. *(laughter)* So we're starting to see some questions in through LiveMeeting and of course let more folks in they can also press star 1 if they would want to ask a question via audio. Let me go ahead and tell you one of the, the questions that has come in from Tres Hunter Schnell, 'How do you, Dr. Fielding, how do you link the core functions and essential services to the individual population health measures?'

JF: I'm not sure we, we link them. I think we link them in groups as I suggested on one of the slides. I think those are crosscutting opportunities. And there's some that are going to lend themselves to some of the policy opportunities, others to programmatic opportunities. So I would not see an inextricable link between any two of those. But I think you have to ask yourself which of those ten essential functions are important to advancing a goal with respect to a particular topic.

LC: Okay. Thank you so much. And here's another question. 'In accreditation there's a tension to both help departments strategic plan and a community plan with partners. How do you see this work connecting to both or could you elaborate on that?'

JF: Well, of course we're early in our days of accreditation but I do think it's really important that the plan that helped the department develop has stakeholder input. We developed a strategic plan and in doing that we did interviews with a number of folks outside of our key stakeholders in the health community and integrated that into our plan. Now at the individual community level, there can be variations from that in terms of emphasis because in fact there may be problems that are localized in some areas. As an example, we have a couple of parts of our big county where we have really huge disparities in the rates of infant mortality. And we had to really look at those. Overall our numbers may not look bad and we might not have a priority. But at the community level it could well be a priority. In the overall strategic plan needs to be an overall guiding stock, not one that precludes looking at problems that may be very strongly perceived in communities. On the other hand, part of our job also is to in some cases push back a little bit when communities have concerns. I'll give you examples. Here there is a lot of concern about cancer clusters. We could spend all our time looking at cancer clusters, even though we are almost a hundred percent sure we would never find a cancer cluster, just because that happens to be near a landfill and you know, so we have to in fact provide education to communities so they understand what's possible and what's likely in terms of what we know in epidemiology. Having



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said that it's important to be sensitive to those concerns because if you don't respond to those concerns, the other ones that you may think are more important may not get very much community support.

LC: Okay. Thank you so much. Dr. Fielding, in the last several weeks there's been some discussion among the Performance Improvement Managers Network members about software for performance management. And how to pull together some of the work that folks are doing in a way that they can track it and, could you talk a little bit about your health department's experiences with that or how you've been able to do this?

JF: I don't think we've used any sophisticated software but I would leave that to the folks that are really working on it, Dr. Gunzenhauser, Dr. Jacobsen to answer and would be happy to provide that feedback, back to you. I don't have specific information on what software we're using. I think that what's important is that you find something that meets your needs. And I'm not familiar with the full gamut of possibilities. So we'll give you whatever we can.

LC: Okay.

Operator: If you would like to ask a question on the phone please press star 1 on your touchtone phone. To withdraw your request at any time, please press star 2. Again if you would like to ask a question on the phone, please press star 1. One moment please. *(Pause for 20 seconds)*.

And at this time, I am showing no questions on the phone.

LC: Dr. Fielding, one other question has come in via the webinar. 'Does some of the work that you've shared link to or so I'll elaborate, if so how to any work being done at the state level in California?

JF: We do work very closely with the state. I'm actually on the advisory board for the public health department at the state level so we are working very closely with the state on a number of these priorities. Again, we're a very large metropolitan area. We have 88 cities so we're also trying to be responsive at the local level to the varying needs of those. But yes we are in close collaboration with the state on a wide variety of issues. We've had input into the state's strategic plan, into the state's priorities. And while there won't be you know coincident in every respect, they're very compatible.

LC: Okay and yet another question just popped up on the webinar so, and just looking at the time now, so let me ask this question but also, I think, if anyone has burning questions please submit them, otherwise we'll probably start drawing to a close after this. You've talked a lot about the community guide and evidence based practices, what about promising practices or merging practices given that a lot of public health interventions don't have a strong evidence base.

JF: I think that's an excellent question. I'm really glad that it was asked. I think we have to focus increasingly on harvesting the wisdom from practice-based evidence. And we need to have more systematic ways of doing that. We need to fund more of that. I think that there's a couple of issues. First



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of all I wouldn't put a huge amount of resources into interventions for areas where we don't know what works unless they are of critical importance and they have you know, very high burden. In the case of obesity for example we have a lot of information but the epidemic was so major that we felt it was essential to respond so in this case we have the Robert Wood Johnson Foundation, the Institute of Medicine, came up with a bunch of quote "promising practices" that we're all now working on, but in that situation what we have to do is make sure we don't put anything in place that we don't very carefully evaluate. I think what is concerning is sometimes we put a lot of resources to something where there is no evidence instead of putting-using the interventions that we know can be effective. I think we need to try to for those others that we don't have very much clear evidence, we need to accumulate groups of potential promising practices that make sure if they're put in place, that they're done in a way that have careful evaluation. So we don't wind up with the same problem five years hence where people have done things but they haven't had the kind of critical evaluation that allows us to assess if there's a level of effectiveness that would lead to a recommendation.

LC: Thank you. I think that was very helpful. It's certainly all about moving practices up that trajectory to becoming more evidence based. Well we are only a few minutes from our end time, so as to keep us on time I want to move on. And Dr. Fielding I want to thank you and of course I want to thank all of the performance improvement managers and, and everyone else who has joined us today, but thank you so much for sharing your wisdom and that very helpful overview of both The Community Guide and Healthy People as well as your experiences in Los Angeles. I think—

JF: Well I look forward to seeing the work of all these quality assurance performance oriented managers, and the work that you do the more that it can get into peer reviewed form, into briefs, into, you know, reports in the field, that we can all look at, the more we can all learn collectively so thank you in advance for what you're going to do and thank you for what you've already done.

LC: Yeah, wouldn't that be great if a lot of the work that we're doing ends up yielding all sorts of new fodder for The Community Guide. I think that's certainly an opportunity. So thank you again, and now we're going to, before we leave today, we do have one more poll for everyone and a few announcements about our upcoming webinars.

First the poll. The question is: How would you rate this webinar overall? The poll is open.

Great and while folks are casting their vote, certainly if you'd like to give us additional feedback on the call or suggest topics for future calls, please don't forget you can email us at pimnetwork@CDC.gov. We hope you'll plan to join us on the upcoming conference calls on May 26th. Our next call will be exploring the use of the Multistate Learning Collaborative; the individual and aggregate learnings and resources that has come from that five year initiative and the sixteen states who have been a part of that. Our June 24th call will highlight software for performance management systems and that's a topic that of course was drawn from some of the discussions that have occurred among performance improvement managers and we'll showcase some NPHII grantees that do have performance management systems as



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well as have a little discussion among that. And also be aware for future calls beyond that we're really planning to think about some of the interactive opportunities among Network members so that you all can be sharing what you're doing with each other. So please stay tuned for how we're going to support that. In the meantime don't forget of course, you can view and download all the proceedings from the calls from the PIM Network web conference calls series on both on the website as well as the phConnect virtual community. So thank you again. We've perfectly reached our time. Dr. Fielding, thank you for keeping us on time and for a very rich discussion and presentation and thanks to everyone who joined us today.

JF: Thank you.



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